STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001114	A. BUILDING: **01** B. WING _____	R **05/05/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCIFUL HANDS	**1313 ELRADO STREET** **BURLINGTON, NC 27217**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments Report by Paul Dixon A Biennial Follow-Up Survey was conducted on May 5, 2015 from 9:15 AM to 9:50 AM. Not all previously cited deficiencies have been corrected; therefore further action is required.	{C 000}		
{C 174}	Building Equipment Maintained Safe, Operating SECTION .0300 - THE BUILDING 10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition. (j) This Rule shall apply to new and existing family care homes. This Rule is not met as evidenced by: 3. The outlet at the front porch does not have a protective cover. Contract a licensed electrician to install a cover. 05/05/2015-PD: Based on observations during the Follow-Up Survey, the protective cover is still missing. Contact a qualified technician to install a weather-proof cover on the outlet. Proof of completed work must be provided by way of receipts, invoices, photographs, etc. Forward proof of completed work with you plan of correction. 10. The exterior outlet at the back of the facility did not have power and would not reset. Contract a qualified technician to repair or replace this outlet. Provide documentation of the repairs. 05/05/2015-PD: Based on observations during	{C 174}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001114	A. BUILDING: **01** B. WING _____	R **05/05/2015**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 174}	Continued From page 1 the Follow-Up Survey, the outlet is still without power. Contract a qualified technician to repair or replace this outlet. Provide documentation of the repairs. Proof of completed work must be provided by way of receipts, invoices, photographs, etc. Forward proof of completed work with you plan of correction.	{C 174}		
{C 138}	Outside Entrances/Exits-Single Hand Motion T10: 42C .2209 OUTSIDE ENTRANCES AND EXITS (d) All exit doors locks must be easily operable, by a single hand motion, from the inside at all times without keys. This Rule is not met as evidenced by: 1. The front door hardware is not single action. Contract a qualified vendor to replace the hardware with single action hardware. Provide documentation of the repairs. 05/05/2015-PD: Based on observations during the Follow-Up Survey, the door is still not single action hardware. Contract a qualified vendor to replace the hardware with single action hardware. Provide documentation of the repairs.	{C 138}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
FCL001114	A. Building 01 - MAIN B. Wing	5/5/2015

Name of Facility	Street Address, City, State, Zip Code
MERCIFUL HANDS	1313 ELRADO STREET BURLINGTON, NC 27217

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix C0143 Reg. # LSC	Correction Completed 05/05/2015	ID Prefix C0155 Reg. # LSC	Correction Completed 05/05/2015	ID Prefix C0157 Reg. # LSC	Correction Completed 05/05/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/13/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
FCL001114	A. Building B. Wing **01 - MAIN**	5/5/2015

Name of Facility	Street Address, City, State, Zip Code
MERCIFUL HANDS	1313 ELRADO STREET BURLINGTON, NC 27217

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **C0117** Reg. # LSC	**05/05/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/13/2014

_____ **Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**